Senate

General Assembly

File No. 246

February Session, 2010

Substitute Senate Bill No. 248

Senate, April 1, 2010

The Committee on Public Health reported through SEN. HARRIS of the 5th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING ADVERSE EVENTS AT HOSPITALS AND OUTPATIENT SURGICAL FACILITIES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 19a-127n of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2010*):

(a) (1) For purposes of this section, an "adverse event" means any event that is identified on the National Quality Forum's List of Serious Reportable Events or on a list compiled by the Commissioner of Public Health and adopted as regulations pursuant to subsection (d) of this section; and "corrective action plan" means a plan that implements strategies that reduce the risk of similar adverse events occurring in the future, and measures the effectiveness of such strategies by addressing the implementation, oversight and time lines of such strategies.

(2) The commissioner shall review the list of adverse events periodically, but not less than annually, to ascertain whether any

additions, deletions or modifications to the list are necessary.

(b) On and after October 1, 2002, a hospital or outpatient surgical facility shall report adverse events to the Department of Public Health on a form prescribed by the **[**Commissioner of Public Health**]** commissioner as follows: (1) A written report and the status of any corrective steps shall be submitted not later than seven days after the date on which the adverse event occurred; and (2) a corrective action plan shall be filed not later than thirty days after the date on which the adverse event occurred. Emergent reports, as defined in the regulations adopted pursuant to subsection (c) of this section, shall be made to the department immediately. Failure to implement a corrective action plan may result in disciplinary action by the commissioner, pursuant to section 19a-494, as amended by this act.

(c) The **[**Commissioner of Public Health**]** commissioner shall adopt regulations, in accordance with chapter 54, to carry out the provisions of this section. Such regulations shall include, but shall not be limited to, a list of adverse events that are in addition to those contained in the National Quality Forum's List of Serious Reportable Events.

(d) On or before October first annually, the commissioner shall report, in accordance with the provisions of section 11-4a, on adverse event reporting, to the joint standing committee of the General Assembly having cognizance of matters relating to public health. For reports submitted on or after July 1, 2010, the commissioner shall include: (1) The name of the hospital or outpatient surgical facility where such adverse event occurred, and (2) a summary of the hospital or outpatient surgical facility's corrective action and whether the department has reviewed the implementation of such corrective action. The commissioner, to the extent practicable, shall provide the information required pursuant to this subsection, in a format that reflects the contextual nature and circumstances surrounding the adverse event. Contextual information may include, but need not be limited to, the population served by the hospital or outpatient surgical facility, and the health circumstances of the presenting patient.

(e) Information collected pursuant to this section shall not be disclosed pursuant to subsection (a) of section 1-210 at any time, and information collected pursuant to this section shall not be subject to subpoena or discovery or introduced into evidence in any judicial or administrative proceeding except as otherwise specifically provided by law. Nothing in this section shall be construed to limit access to or disclosure of investigative files, including any adverse event report contained in such files, maintained by the department as otherwise provided in section 19a-499.

(f) If the department determines that it will initiate an investigation of an adverse event that has been reported, such investigation may include review by one or more practitioners with clinical expertise of the type involved in the reported adverse event.

(g) **[**The Quality of Care Advisory Committee established pursuant to section 19a-127*l* shall establish methods for informing the public regarding access to the department's consumer and regulatory services.**]** No hospital or outpatient surgical facility shall discharge, refuse to hire, refuse to serve, retaliate in any manner or take any adverse action against any employee, applicant for employment or health care provider because such employee, applicant for employment or health care provider takes or has taken any action in furtherance of the enforcement of the provisions of this section.

Sec. 2. Section 19a-494 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2010*):

(a) The Commissioner of Public Health, after a hearing held in accordance with the provisions of chapter 54, may take any of the following actions, singly or in combination, in any case in which **[**he**]** the commissioner finds that there has been a substantial failure to comply with the requirements established under this chapter, the Public Health Code and licensing regulations:

(1) Revoke a license or certificate;

(2) Suspend a license or certificate;

(3) Censure a licensee or certificate holder;

(4) Issue a letter of reprimand to a licensee or certificate holder;

(5) Place a licensee or certificate holder on probationary status and require **[**him**]** such licensee or certificate holder to report regularly to the department on the matters **[**which**]** that are the basis of the probation;

(6) Restrict the acquisition of other facilities for a period of time set by the commissioner; **[**and**]**

(7) Issue an order compelling compliance with applicable statutes or regulations of the department; and

(8) Impose a civil penalty of not more than ten thousand dollars for each violation of applicable statutes or regulations. Each violation shall be a separate and distinct offense and, in the case of a continuing violation, each day of the continuance thereof shall be deemed a separate and distinct offense.

(b) Notice of the hearing to the holder of a license or certificate shall be effected by registered or certified mail or by personal service, setting forth the particular reasons for the proposed action and fixing a date, not less than thirty days from the date of such mailing or service, at which the holder of such license or certificate shall be given an opportunity for a prompt and fair hearing, and witnesses may be subpoenaed by either party for such hearing. Such hearing may be conducted by the Commissioner of Public Health, a deputy commissioner, or by a member of the Department of Public Health, designated by said commissioner. On the basis of such hearing, or upon default of the holder of such license or certificate, the person conducting such hearing shall specify his or her findings and conclusions, and said department may, upon the basis of such findings and conclusions take any action authorized by this section that it deems necessary. A copy of such decision shall be sent by registered or

certified mail or served personally upon the holder of such license or certificate.

Sec. 3. Section 19a-127*l* of the 2010 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2010*):

(a) There is established a quality of care program within the Department of Public Health. The department shall develop for the purposes of said program (1) a standardized data set to measure the clinical performance of health care facilities, as defined in section 19a-630, and require such data to be collected and reported periodically to the department, including, but not limited to, data for the measurement of comparable patient satisfaction, and (2) methods to provide public accountability for health care delivery systems by such facilities. The department shall develop such set and methods for hospitals during the fiscal year ending June 30, 2003, and the committee established pursuant to subsection (c) of this section shall consider and may recommend to the joint standing committee of the General Assembly having cognizance of matters relating to public health the inclusion of other health care facilities in each subsequent year.

(b) In carrying out its responsibilities under subsection (a) of this section, the department shall develop the following for the quality of care program:

(1) Comparable performance measures to be reported;

(2) Selection of patient satisfaction survey measures and instruments;

(3) Methods and format of standardized data collection;

(4) Format for a public quality performance measurement report;

(5) Human resources and quality measurements;

(6) Medical error reduction methods;

(7) Systems for sharing and implementing universally accepted best practices;

(8) Systems for reporting outcome data;

(9) Systems for continuum of care;

(10) Recommendations concerning the use of an ISO 9000 quality auditing program;

(11) Recommendations concerning the types of statutory protection needed prior to collecting any data or information under this section and sections 19a-127m and 19a-127n, as amended by this act; and

(12) Any other issues that the department deems appropriate.

(c) (1) There is established a Quality of Care Advisory Committee which shall advise the Department of Public Health on the issues set forth in subdivisions (1) to (12), inclusive, of subsection (b) of this section. The advisory committee shall meet at least semiannually.

(2) Said committee shall create a standing subcommittee on best practices. The subcommittee shall (A) advise the department on effective methods for sharing with providers the quality improvement information learned from the department's review of reports and corrective action plans, including quality improvement practices, patient safety issues and preventative strategies, (B) not later than January 1, 2006, review and make recommendations concerning best practices with respect to when breast cancer screening should be conducted using comprehensive ultrasound screening or mammogram examinations, and (C) not later than January 1, 2008, study and make recommendations to the department concerning best practices with respect to communications between a patient's primary care provider and other providers involved in a patient's care, including hospitalists and specialists. The department shall, at least quarterly, disseminate information regarding quality improvement practices, patient safety

issues and preventative strategies to the subcommittee and hospitals.

(d) The advisory committee shall consist of (1) four members who represent and shall be appointed by the Connecticut Hospital Association, including three members who represent three separate hospitals that are not affiliated of which one such hospital is an academic medical center; (2) one member who represents and shall be appointed by the Connecticut Nursing Association; (3) two members who represent and shall be appointed by the Connecticut Medical Society, including one member who is an active medical care provider; (4) two members who represent and shall be appointed by the Connecticut Business and Industry Association, including one member who represents a large business and one member who represents a small business; (5) one member who represents and shall be appointed by the Home Health Care Association; (6) one member who represents and shall be appointed by the Connecticut Association of Health Care Facilities; (7) one member who represents and shall be appointed by the Connecticut Association of Not-For-Profit Providers for the Aging; (8) two members who represent and shall be appointed by the AFL-CIO; (9) one member who represents consumers of health care services and who shall be appointed by the Commissioner of Public Health; (10) one member who represents a school of public health and who shall be appointed by the Commissioner of Public Health; (11) the Commissioner of Public Health or said commissioner's designee; (12) the Commissioner of Social Services or said commissioner's designee; (13) the Secretary of the Office of Policy and Management or said secretary's designee; (14) two members who represent licensed health plans and shall be appointed by the Connecticut Association of Health Care Plans; (15) one member who represents and shall be appointed by the federally designated state peer review organization; and (16) one member who represents and shall be appointed by the Connecticut Pharmaceutical Association. The chairperson of the advisory committee shall be the Commissioner of Public Health or said commissioner's designee. The chairperson of the committee, with a vote of the majority of the members present, may appoint ex-officio nonvoting members in specialties not represented among voting

members. Vacancies shall be filled by the person who makes the appointment under this subsection.

(e) The chairperson of the advisory committee may designate one or more working groups to address specific issues and shall appoint the members of each working group. Each working group shall report its findings and recommendations to the full advisory committee.

(f) The Commissioner of Public Health shall report on the quality of care program on or before June 30, 2003, and annually thereafter, in accordance with section 11-4a, to the joint standing committee of the General Assembly having cognizance of matters relating to public health and to the Governor. Each report on said program shall include activities of the program during the prior year and a plan of activities for the following year.

(g) On or before April 1, 2004, the Commissioner of Public Health shall prepare a report, available to the public, that compares all licensed hospitals in the state based on the quality performance measures developed under the quality of care program.

(h) (1) The advisory committee shall examine and evaluate (A) possible approaches that would aid in the utilization of an existing data collection system for cardiac outcomes, and (B) the potential for state-wide use of a data collection system for cardiac outcomes, for the purpose of continuing the delivery of quality cardiac care services in the state.

(2) On or before December 1, 2007, the advisory committee shall submit, in accordance with the provisions of section 11-4a, the results of the examination authorized by this subsection, along with any recommendations, to the Governor and the joint standing committee of the General Assembly having cognizance of matters relating to public health.

(i) The advisory committee shall establish methods for informing the public regarding access to the department's consumer and

regulatory services.

[(i)**]** (j) The Department of Public Health may seek out funding for the purpose of implementing the provisions of this section. Said provisions shall be implemented upon receipt of **[**said**]** such funding.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2010*	19a-127n
Sec. 2	*July 1, 2010*	19a-494
Sec. 3	*July 1, 2010*	19a-127*l*

PH *Joint Favorable Subst.*

OFA Fiscal Note

State Impact: None

Municipal Impact: None

Explanation

The bill is not anticipated to result in a fiscal impact. It allows for the Department of Public Health (DPH) to impose a civil penalty of not more than $10,000 for substantial failure of health care institutions to comply with certain DPH requirements, following a hearing under the Uniform Administrative Procedure Act. There were 195 DPH complaint investigations of hospitals in FY 09, fifty of which were related to adverse events. However, no hearings were held as the agency negotiated settlements with institutions through consent orders. Thus, it is unlikely that a civil penalty will be imposed due to the provisions of this bill.

The Out Years

State Impact: None

Municipal Impact: None

OLR Bill Analysis

sSB 248

AN ACT CONCERNING ADVERSE EVENTS AT HOSPITALS AND OUTPATIENT SURGICAL FACILITIES.

SUMMARY:

This bill amends the state's adverse event reporting law by requiring that the Department of Public Health's (DPH) annual report to the legislature on adverse events include (1) the names of the hospitals and outpatient surgical facilities where adverse events occurred and (2) a summary of each facility's corrective action plan and whether DPH has reviewed its implementation.

The bill prohibits a facility from taking certain actions against an employee or job applicant for actions taken to further provisions of the adverse event law.

The bill adds a civil penalty of up to $10,000 to the disciplinary actions DPH can take against a health care institution for substantial failure to comply with department requirements, the Public Health Code, and licensing regulations. Each violation is a separate and distinct offense and if the violation persists, each day is considered a separate and distinct offense.

EFFECTIVE DATE: July 1, 2010

ADVERSE EVENT REPORTING

Current Law

By law, hospitals and outpatient surgical facilities must report adverse events to DPH on a specific department form and within seven days after the event occurred. Separate reports must be submitted for each adverse event that affects a patient while in the

facility. An adverse event is any event that is identified on the National Quality Forum's (NQF) "List of Serious Reportable Events" or on a list compiled by DPH. NQF's list includes 28 events in six major categories that may occur in hospitals and outpatient facilities. DPH has added five Connecticut-specific adverse events to the NQF list.

The reporting form asks for:

1. facility information (type of hospital, i.e. general, children's, chronic disease, mental health, maternity; outpatient surgical facility);

2. patient information, including the date and time of the adverse event and when it was first known;

3. location of the event (e.g., emergency room, operating room, outpatient setting, surgical unit, neonatal intensive care);

4. notifications made (to patient, other state agencies, local or state police, others);

5. description of the adverse event (e.g., event facts and status of the patient's condition, immediate plan of action to reduce the risk of a similar event); and

6. a corrective action plan (a plan must be filed within 30 days after any adverse event occurs).

After screening an adverse event report, including a corrective action plan, DPH determines whether to initiate an investigation.

Reporting of Adverse Events

DPH must report annually by October 1 to the General Assembly on adverse events. Under current law, the information collected on adverse events is not disclosed and is not subject to subpoena, discovery, introduction into evidence in any judicial or administrative procedure except as specifically provided by law. DPH's report does

not identify specific hospitals, outpatient surgical facilities, or individuals with reported adverse events. The annual reports lists adverse events by (1) frequency of occurrence based on the NQF and Connecticut-specific lists of adverse events and (2) facility type, patient age, and facility location.

The bill requires that DPH include in its annual reports after July 1, 2010 the name of the hospital or outpatient facility where the adverse event occurred. It must also include a summary of the facility's corrective action plan and whether DPH has reviewed the plan's implementation. DPH, to the extent practicable, must provide the required information in a format that reflects the contextual nature and circumstances surrounding the adverse event. "Contextual information" may include the population served by the hospital or surgical facility and the patient's health circumstances.

EMPLOYEE PROTECTION

The bill prohibits a hospital or outpatient surgical facility from discharging, refusing to hire, refusing to serve, retaliating in any manner, or taking any adverse action against an employee, job applicant, or health care provider because that individual takes action to further the enforcement of the adverse event law.

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute
Yea 29 Nay 1 (03/19/2010)